American Federation of Labor and Congress of Industrial Organizations

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December 6, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Attention: Requirements Related to Surprise Billing; Part 2 [CMS – 9909 – IFC]
(RIN: 0938-AU62; Document Number: 2021-21441)

Dear Secretaries Becerra, Walsh and Yellen:

The American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) writes in response to the recent Interim Final Rule (IFR) implementing provisions of the *No Surprises Act* (Requirements Related to Surprise Billing; Part II, RIN 0938-AU63). The AFL-CIO is a voluntary, democratic federation of 57 affiliated unions representing more than 12.5 million workers across the country in all sectors of our economy. The AFL-CIO is committed to fairness in the workplace and health security for working people and their families. Our core mission is to ensure that working people are treated fairly and with respect, that our hard work is rewarded with family-supporting wages and benefits, and that our workplaces are safe. We also provide an independent voice in politics and legislation for working women and men and make their voices heard in corporate boardrooms and the financial system.

The AFL-CIO strongly supports the objectives of the *No Surprises Act*[1], which bars higher out-of-pocket costs when a consumer is unknowingly cared for by an out-of-network clinician at an in-network facility. The statute resolves payment disputes between health plans and providers by creating an independent dispute resolution process (IDR) in which an arbitrator chooses one of the parties' proposed payment offers.

We commend the Administration for a regulation that faithfully implements critical provisions of the legislation. We believe the IFR as drafted is a critical step in protecting working families from the burdensome practice of surprise billing without increasing premiums. We urge the tri-agencies involved in the implementation process not to make major changes to the regulation, particularly the payment determination provisions.

Early research indicates that the practice of surprise billing has cost working families covered by employer-sponsored insurance at least $40 billion annually.[2] Before the passage of legislation, nearly one in five inpatient hospital admissions and one in ten elective hospital admissions resulted in a surprise bill.[3] The problem may well be more acute for union workers and their families since they are far more likely to have access to and participate in employer-sponsored insurance. The AFL-CIO is therefore particularly interested in stopping this practice.[4] At the same time, the AFL-CIO is particularly interested in a federal solution, given the number of private-sector union members with coverage from health plans exempt from state regulation.

Surprise billing is a complex issue, and the AFL-CIO is concerned about policy prescriptions that may have unintended consequences for union-affiliated health plans. Millions of union workers are covered by multi-employer health plans financed by worker and employer contributions over a three-to-five-year period. The fixed nature of this funding leaves the health plans particularly vulnerable to medical inflation. If health care costs go up, trustees of these funds face the need to reduce benefits or adjust eligibility rules to offset new costs. The AFL-CIO seeks to stop the egregious practice of surprise billing without increasing medical inflation. For many working families, such an outcome would just substitute one financial burden for another.

Central Role of the QPA

We strongly support the basic design of the arbitration process detailed in the IFR, which starts with the presumption that the Qualified Payment Amount (QPA) is the appropriate payment amount. A party may overcome this presumption by submitting information "clearly demonstrating" that the QPA is "materially different" from the appropriate out-of-network payment.[5] This rebuttable

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[1] Division BB, section 109 *et seq*. of the *Consolidated Appropriations Act*, Pub. L. No. 116-260, 134 Stat. 1182. Available at https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf.

[2] Zack Cooper, Hao Nguyen, Nathan Shekita, and Fiona Scott Morton, *Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians*, Health Affairs, Vol. 39, No. 1. December 3, 2019. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00507.

[3] Christopher Garmon and Benjamin Chartock, *One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills*, Health Affairs, Vol. 36, No. 1. 2017. Available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970.

[4] *Union Workers More Likely Than Nonunion Workers To Have Healthcare Benefits In 2019*, The Economics Daily, Bureau of Labor Statistics, October 28, 2019. Available at https://www.bls.gov/opub/ted/2019/union-workers-more-likely-than-nonunion-workers-to-have-healthcare-benefits-in-2019.htm.

[5] *Part II Interim Final Rule with Comment Period*, Vol. 86 Federal Register No. 192, 55984, October 7, 2021. See also *Fact Sheet: Requirements Related to Surprise Billing; Part II Interim Final Rule with Comment Period*, Center for Medicare and Medicaid Services, September 30, 2021. Washington, DC. Available at

presumption is supported by the structure of the statute, which lists the QPA as the one mandatory element of any dispute settlement. Additional factors are listed in a separate second section that either party may invoke. As the lawmakers deeply involved in the legislative process have noted, "the law designates the QPA as the only factor that must be submitted and considered without qualification in every dispute under consideration by the IDR entity." [6]

Other elements of the *No Surprises Act* signal the intent of lawmakers to assign the QPA the central role in the outcome of the arbitration. The statute is very detailed in how it defines the QPA (the median contracted rate for similar items and services, taking into account geographic area and differences between insurance markets; this figure is adjusted for the consumer price index for urban consumers[7]). Factors such as experience and training of a provider were considered by lawmakers to be "relatively minor items" that have "less utility in determining the appropriate payment amount" compare to the QPA and "should not be given equal weight."[8] The statute also includes federal oversight of how plans calculate the QPA and the frequency in which the payment selected by arbitrators exceeds the QPA. No similar oversight is mandated or even described for other factors. Overall, there is solid textual evidence to support the conclusion that the QPA was intended to have the primary role in the IDR process envisioned by the *No Surprises Act*.

Policy Justifications

For workers, there are significant policy advantages to an arbitration process built around the QPA. First, an IDR process built around the QPA is unlikely to hinder access to care or create market conditions that lead to shortages of physicians in-network. An IDR process centered on the QPA is in fact likely to remove current disincentives for providers to join networks. This will reduce incidents of balance billing in the future.

From a data perspective, there is no justification for giving factors such as patient acuity and complexity of care the same weight in the IDR process as the QPA. As the IFR preamble notes, service codes and modifiers usually reflect patient acuity and complexity of care, so these factors will already be incorporated into the QPA. Only in rare cases is that not the case.

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https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-ii-interim-final-rule-comment-period

[6] Letter from Rep. Robert C. "Bobby" Scott (D-VA), chairman of the House Education and Labor Committee and Rep. Virginia Foxx (R-NC) regarding the *Interim Final Rule – Requirements Related to Surprise Billing; Part II*, to the Hon. Xavier Becerra, Secretary of the Department of Health and Human Services, the Hon. Martin J. Walsh, Secretary of the Department of Labor, and the Hon. Janet, Yellen, Secretary of the Treasury, November 19, 2021. Available at https://edlabor.house.gov/media/press-releases/chairman-scott-ranking-member-foxx-express-bipartisan-support-for-surprise-billing-protections. *See also* Letter from Rep. Frank Pallone (D-NJ), chairman of the House Committee on Energy and Commerce and Sen. Patty Murray (D-WA), chair of the Senate Health, Education, Labor, and Pensions Committee, regarding the *Interim Final Rule – Requirements Related to Surprise Billing; Part II*, to the Hon. Xavier Becerra, Secretary of the Department of Health and Human Services, the Hon. Martin J. Walsh, Secretary of the Department of Labor, and the Hon. Janet, Yellen, Secretary of the Treasury, October 20, 2021. Available at https://energycommerce.house.gov/newsroom/press-releases/pallone-murray-voice-support-for-biden-administration-s-surprise-billing.

[7] Consolidated Appropriations Act, Pub. L. No. 116-260, *supra*, page 1582. Available at https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf. *See also* sec. 2799A-1(a)(3)(E) of the Public Health Services Act.

[8] Scott and Foxx letter, *supra*.

Creating a Fair Process

The IFR creates an equitable and efficient process for addressing the burden of surprise bills. While the QPA anchors the IDR process, arbiters must at least consider other factors when there is documented evidence that they have had a material impact on the care provided. It is not unreasonable to require a party to document why the QPA is not the appropriate payment. Nothing in the IFR requires a provider to undertake an arduous or expensive process to demonstrate the importance of a secondary factors listed in section 103(b)(5)(C)(ii) of the statute and elsewhere. For example, a provider must demonstrate that their training and experience had an actual impact on the care provided. We believe that any lesser requirement could allow a party to the dispute to tie up the arbitration process with unsupportable claims. This would undermine the credibility of the arbitration process that Congress thought was an integral part of solving such disputes. This is particularly true given the broad ability of providers to batch claims.

As a related matter, we support the view expressed in the Preamble to the IFR that an arbitrator is not required to accept the out-of-network rate of the provider simply because he or she has been able to document the material difference that the secondary factor may have had on the care provided. As the Departments notes in the Preamble, a payment decision which is higher than the QPA should be supported by ample evidence and proof that the care provided justifies a payment other than the QPA.[9] We urge the Departments to issue guidance that reiterates this point and clarifies the kind of documentation necessary to overcome the presumption.

The Departments also propose that when providers choose to batch claims in an arbitration case, the parties can provide different offers for individual items that are batched, provided that the same offer apply to all items and services that have the same QPA.[10] We support the Departments in their creation of standards in regards to batching claims and applaud the Departments for continuing to center the QPA in all cases of arbitration to ensure that health care costs are held down for workers and their families.

Finally, the statute explicitly bars arbitrators from considering reimbursement rates of public programs or billed charges posted by private-sector providers.[11] We believe that billed charges include not only the retail price an uninsured patient may be charged, but also the amount that an insured patient consents to pay an out-of-network provider in advance of providing that care. These latter payments are akin to billed charges since they are unilateral demands by providers, not a rate negotiated by two parties at arms-length or the market-driven realities of a QPA; an arbitrator should not be allowed to consider such an amount when deciding which payment offer to accept. We urge the Departments to issue guidance that reiterates this point and clarifies the inadmissibility of reimbursement amounts a provider customarily receives from patients that knowingly consent to in exchange for care by an out-of-network clinician.

Strengthening the IFR

We thank the Administration for an IFR that is likely to limit outlier payments and realize savings. We believe the design of the IDR process will make it more likely that the *No Surprises Act* will meet the goals of addressing outlier payments and reducing health premiums. At the same time, we believe there are ways the IFR could be strengthened without adversely affecting any of the current requirements that shield consumers from higher premiums in the future.

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[9] *Part II Interim Final Rule with Comment Period*, Vol. 86 Federal Register No. 192, 55995, October 7, 2021.
[10] Ibid.
[11] *Part II Interim Final Rule with Comment Period*, Vol. 86 Federal Register No. 192, 55999, October 7, 2021.

Conflict of Interest Rules
Robust conflict of interest rules are critical for ensuring public confidence in the fairness of the IDR process. The IFR bars an arbitrator or a certified IDR entity that cannot "make an unbiased or impartial payment determination." The IFR defines that to include circumstances where an IDR entity or the arbitrator has a material, familial, financial, or professional relationship with "a party" to the dispute.[12] We would broaden this standard to include ties any person or entity where the arbitrator stands to gain financially from a resolution of the payment dispute.

Broader language is justified by the massive investments that private equity firms have made in hospitals and medical staffing firms. These are the entities responsible for the widespread use of surprise bills. Since 2015, the annual amount equity firms have invested in health care has tripled, reaching $80 billion in 2019 alone.[13] We are concerned that under the proposed rules an arbitrator could, through the investments of family members, have a financial stake in the outcome of the dispute.

Hence, we suggest broadening the conflict-of-interest rules to include ties to any party that has a financial stake in the outcome of the dispute. For example, if an arbitrator's spouse had shares in the private equity firm that was a major investor in a staffing firm, then that arbitrator should be barred from settling a dispute involving any client of that staffing firm. If one goal of a conflict of interest rule is to avoid the appearance that an entity or individual is influenced by their own private interests, then the rules must reflect the extensive web of interests that are present in the world of surprise bills.

Conclusion
We applaud the federal agencies for crafting an interim final rule that anchors the IDR process in the QPA. Such a rule should finally limit the ability of out-of-network providers to set reimbursement levels far above market rates through the use of balance billing. We thank the Biden administration for its diligent work on this issue over the last year and its bold efforts to protect working families from the harmful and unfair practice of surprise billing.

Sincerely,

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[12] *Part II Interim Final Rule with Comment Period*, Vol. 86 Federal Register No. 192, 55987, October 7, 2021
[13] *US Congress Investigates Effects Of $80bn Private Equity Industry On Government Healthcare Programme*, British Medical Journal, 370:m3490, September 7, 2020. Available at https://www.bmj.com/content/370/bmj.m3490.